MyEChart
Patient Authorization Form

If you would like an individual such as a spouse to be able to access your MyEChart Account, you will need to fill in the following proxy access form.

I authorize the disclosure of my protected health information, as described herein. I understand that this authorization is voluntary. I understand that, if the person that I authorize to receive my protected health information is not subject to federal and state health information privacy laws, subsequent disclosure by such person(s) or organization may not be protected by those laws.

1. I authorize the following person(s) to receive my protected health information, as disclosed by Elliot Health System via the MyEChart Service. This authorization allows this person to access my MyEChart account.

   Name(s):
   Address:
   Relationship to me:

2. The purpose of the disclosure is to provide access to my electronic medical record through Elliot Health System's MyEChart service.

3. I understand that I may revoke this authorization at any time by sending a signed and dated letter to Elliot Health System.

4. If I do not sign this form or if I later revoke my authorization, it will not affect the benefits or services for which I am eligible or that I receive from Elliot Health System.

6. NOTE: Information relating to genetic testing or HIV testing will not be released without your specific authorization. If you want us to release or request information relating to either please initial the appropriate boxes below:

   ____ Genetic Testing

   ____ HIV Diagnosis/Treatment

I confirm that I have had the opportunity to read and consider the contents of this authorization and agree to be bound by them.

_____ _____
Signature of Patient (Required) Date

Patient Name:_____
Address:_____
Telephone: _____ Date of Birth:_____

If this authorization is signed by a personal representative on behalf of this individual, complete the following:

Personal Representative's Name: _____
Description of Personal Representative's Authority: _____